



Aalborg Universitet

AALBORG UNIVERSITY
DENMARK

Renin-Angiotensin System Blockers and Adverse Outcomes of Influenza and Pneumonia

A Danish Cohort Study

Christiansen, Christian Fynbo; Heide-Jørgensen, Uffe; Rasmussen, Thomas Bøjer; Bodilsen, Jacob; Søgaard, Ole Schmeltz; Maeng, Michael; Vistisen, Simon Tilma; Schmidt, Morten; Pottegård, Anton; Lund, Lars Christian; Reilev, Mette; Hallas, Jesper; Johansen, Nanna Borup; Brun, Nikolai Constantin; Sørensen, Henrik Toft; Thomsen, Reimar Wernich

Published in:

Journal of the American Heart Association

DOI (link to publication from Publisher):

[10.1161/JAHA.120.017297](https://doi.org/10.1161/JAHA.120.017297)

Creative Commons License

CC BY-NC-ND 4.0

Publication date:

2020

Document Version

Publisher's PDF, also known as Version of record

[Link to publication from Aalborg University](#)

Citation for published version (APA):

Christiansen, C. F., Heide-Jørgensen, U., Rasmussen, T. B., Bodilsen, J., Søgaard, O. S., Maeng, M., Vistisen, S. T., Schmidt, M., Pottegård, A., Lund, L. C., Reilev, M., Hallas, J., Johansen, N. B., Brun, N. C., Sørensen, H. T., & Thomsen, R. W. (2020). Renin-Angiotensin System Blockers and Adverse Outcomes of Influenza and Pneumonia: A Danish Cohort Study. *Journal of the American Heart Association*, 9(19), [e017297]. <https://doi.org/10.1161/JAHA.120.017297>







General rights

Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

- Users may download and print one copy of any publication from the public portal for the purpose of private study or research.
- You may not further distribute the material or use it for any profit-making activity or commercial gain
- You may freely distribute the URL identifying the publication in the public portal -

ORIGINAL RESEARCH

Renin–Angiotensin System Blockers and Adverse Outcomes of Influenza and Pneumonia: A Danish Cohort Study

Christian Fynbo Christiansen , MD, PhD; Uffe Heide-Jørgensen, MSc, PhD; Thomas Bøjer Rasmussen , MSc; Jacob Bodilsen, MD; Ole Schmeltz Søgaard, MD, PhD; Michael Maeng, MD, PhD; Simon Tilma Vistisen, MSc, PhD; Morten Schmidt, MD, PhD; Anton Pottsgård, MSc, PhD, DMSc; Lars Christian Lund , MD; Mette Reilev , MD, PhD; Jesper Hallas, MD, DMSc; Nanna Borup Johansen , MD, PhD; Nikolai Constantin Brun, MD, PhD; Henrik Toft Sørensen, MD, PhD, DMSc; Reimar Wernich Thomsen , MD, PhD

BACKGROUND: Angiotensin-converting enzyme inhibitors (ACE-Is) and angiotensin receptor blockers (ARBs) may worsen the prognosis of coronavirus disease 2019, but any association could be confounded by the cardiometabolic conditions indicating ACE-I/ARB use. We therefore examined the impact of ACE-Is/ARBs on respiratory tract infection outcomes.

METHODS AND RESULTS: This cohort study included all adult patients hospitalized with influenza or pneumonia from 2005 to 2018 in Denmark using population-based medical databases. Thirty-day mortality and risk of admission to the intensive care unit in ACE-Is/ARBs users was compared with nonusers and with users of calcium channel blockers. We used propensity scores to handle confounding and computed propensity score-weighted risks, risk differences (RDs), and risk ratios (RRs). Of 568 019 patients hospitalized with influenza or pneumonia, 100 278 were ACE-I/ARB users and 37 961 were users of calcium channel blockers. In propensity score-weighted analyses, ACE-I/ARB users had marginally lower 30-day mortality than users of calcium channel blockers (13.9% versus 14.5%; RD, −0.6%; 95% CI, −1.0 to −0.1; RR, 0.96; 95% CI, 0.93–0.99), and a lower risk of admission to the intensive care unit (8.0% versus 9.6%; RD, −1.6%; 95% CI, −2.0 to −1.2; RR, 0.83; 95% CI, 0.80–0.87). Compared with nonusers, current ACE-I/ARB users had lower mortality (RD, −2.4%; 95% CI, −2.8 to −2.0; RR, 0.85; 95% CI, 0.83–0.87), but similar risk of admission to the intensive care unit (RD, 0.4%; 95% CI, 0.0–0.7; RR, 1.04; 95% CI, 1.00–1.09).

CONCLUSIONS: Among patients with influenza or pneumonia, ACE-I/ARB users had no increased risk of admission to the intensive care unit and slightly reduced mortality after controlling for confounding.

Key Words: angiotensin receptor blockers ■ angiotensin-converting enzyme inhibitor ■ cohort study ■ infectious disease ■ intensive care unit

Use of angiotensin-converting enzyme inhibitors (ACE-Is) and angiotensin receptor blockers (ARBs) may increase the risk of developing severe or fatal coronavirus disease 2019 (COVID-19) by upregulating expression of the ACE2 enzyme, which is known to facilitate severe acute respiratory syndrome-coronavirus 2 entry into cells.^{1–5} Case series of hospitalized patients with severe and fatal COVID-19 from China,^{6–8}

Italy,⁹ and the United States^{10,11} have reported a high prevalence (~30%–40%) of hypertension, cardiovascular conditions, and diabetes mellitus—conditions often treated with ACE-Is/ARBs.¹² Data are currently lacking to clarify whether treatment of these coexisting conditions, including ACE-I/ARB use, contributed to the observed adverse health outcomes, or if patients had worse outcomes simply because they were

Correspondence to: Christian Fynbo Christiansen, MD, PhD, Department of Clinical Epidemiology, Aarhus University Hospital, Olof Palmes Alle 43-45, DK-8200 Aarhus N, Denmark. E-mail: cfc@clin.au.dk

Supplementary Material for this article is available at <https://www.ahajournals.org/doi/suppl/10.1161/JAHA.120.017297>

For Sources of Funding and Disclosures, see page 14.

© 2020 The Authors. Published on behalf of the American Heart Association, Inc., by Wiley. This is an open access article under the terms of the Creative Commons Attribution-NonCommercial-NoDerivs License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.

JAHA is available at: www.ahajournals.org/journal/jaha

CLINICAL PERSPECTIVE

What Is New?

- In this large cohort study of more than 500 000 patients hospitalized with influenza or pneumonia, users of angiotensin-converting enzyme inhibitors or angiotensin receptor blockers had no increased risk of intensive care unit admission and a slightly reduced mortality after controlling for confounding.

What Are the Clinical Implications?

- Our data support the current recommendations to avoid discontinuation of angiotensin-converting enzyme inhibitors and angiotensin receptor blockers during the current coronavirus disease 2019 pandemic, unless future evidence contradicts our findings.

Nonstandard Abbreviations and Acronyms

COVID-19	coronavirus disease 2019
PS	propensity score
RD	risk difference

older and suffered from cardiometabolic conditions (ie, confounding by indication).^{2,12–15} A few studies have suggested an association between ACE-I and ARB use and decreased mortality from bacterial pneumonia.^{16–18} Although preadmission ACE-I use has been associated with increased mortality in patients hospitalized for viral diseases,¹⁹ two small studies of patients with COVID-19 do not indicate any increased mortality in inpatient users of ACE-Is/ARBs.^{20,21} Most of the existing studies had limitations: They did not have ACE-I/ARB use as their main exposure, had mixed pneumonia risk and outcome, were biased by studying in-hospital medication after study inclusion, or were small with imprecise estimates.

Major institutions and societies have called for further research and issued warnings against ACE-I/ARB discontinuation in patients with COVID-19,²¹ as drug discontinuation may worsen underlying cardiometabolic conditions.²² Thus, there is an urgent need to clarify the impact of ACE-Is/ARBs on outcomes of lower respiratory tract infections. We report here on a large population-based cohort study investigating the impact of ACE-I/ARB use on intensive care unit (ICU) admission and death following hospitalization for influenza or pneumonia, while controlling for potential confounding by indication by using active antihypertensive drug comparators.

METHODS

The study was approved by the Danish Data Protection Agency (record number 2014-54-0922) through registration at Aarhus University (record number KEA-2017-36/812). Ethics approval and informed consent are not required for registry-based observational studies in Denmark.

Study Design and Setting

This nationwide cohort study included all patients diagnosed with influenza or pneumonia in Danish hospitals from January 1, 2005 through September 30, 2018, with follow-up to October 31, 2018. The study design is summarized in Figure S1. Denmark has a tax-supported healthcare system providing equal access to all acute care, including hospital care for pneumonia.²³ All Danish residents receive a personal identity number at birth or upon immigration, which allows individual-level linkage among medical databases and registries. The Danish Civil Registration System is a population registry that contains data updated daily on the vital status (deceased or alive) and residence of all Danish residents.²⁴ (Because of the sensitive nature of the data collected for this study, requests to access the databases used in this study from researchers at authorized institutions may be sent to the Danish Health Data Authority by e-mail to forskerservice@sundheds-data.dk.)

Influenza and Pneumonia

The study examined all hospitalizations by adult members (aged ≥ 18 years) of the study cohort who had either a primary or secondary diagnosis of influenza or pneumonia using the Danish National Patient Registry data (Figure 1).²⁵ Among other variables, the patient registry includes data on the dates of hospital contact/admission and discharge, primary and secondary diagnoses, and procedure codes. Influenza or pneumonia contacts were not included if preceded by an influenza or pneumonia diagnosis within the prior 3 months, to avoid inclusion of readmissions relating to the same disease episode. Finally, we predefined subgroups diagnosed with influenza or diagnosed with pneumonia with bacterial or unspecified pathogen (codes provided in Table S1).

Outcomes

The primary study outcomes were death within 30 days after hospital admission and ICU admissions during the index hospitalization, including transfers between departments and hospitals after the diagnosis of influenza or pneumonia. Secondary outcomes included organ-supportive treatment during ICU admission with mechanical ventilation,

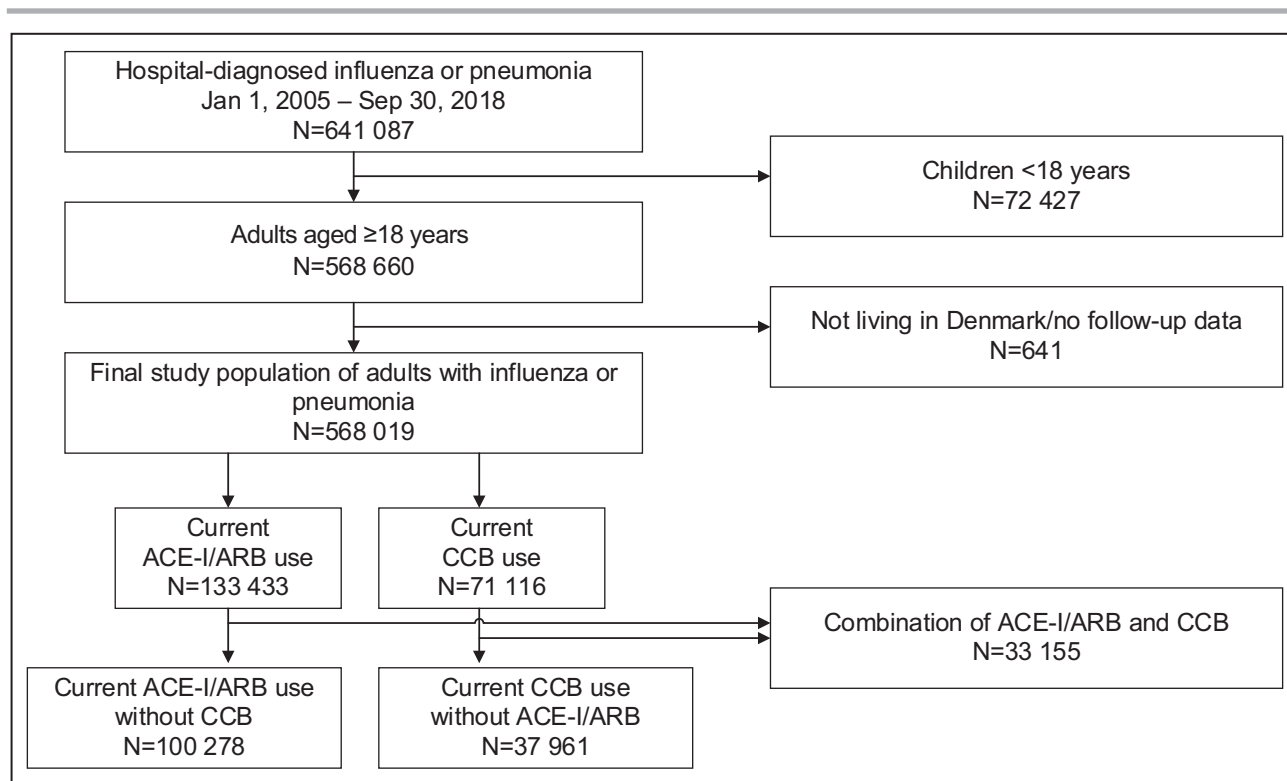


Figure 1. Patient flow diagram.

ACE-I indicates angiotensin-converting enzyme inhibitor; ARB, angiotensin receptor blocker; and CCB, calcium channel blocker.

noninvasive ventilation, and inotropes/vasopressors. Finally, dialysis-treated acute kidney injury was defined as treatment with acute renal replacement therapy in patients with no history of previous dialysis for chronic kidney disease. Outcomes were ascertained using population registry data for all-cause death, and diagnosis and procedure data from the patient registry for all other outcomes.^{24–26}

Exposures

Data on all filled prescriptions for cardiovascular medications were obtained from the Danish National Prescription Registry.²⁷ Our main exposure of interest was current use of either ACE-Is or ARBs. We defined current use as a filled prescription within 90 days before the hospital contact for influenza or pneumonia; most prescriptions for ACE-Is/ARBs filled in Danish pharmacies are for a 3-month supply.

In our main analyses, current ACE-I/ARB users were compared with current calcium channel blocker (CCB) use and with nonusers of ACE-Is/ARBs (no prescription 365 days before index date). We chose CCBs as the active comparator drug because CCBs are also a first-line treatment for hypertension, and have no known pharmacological effects on the renin–angiotensin–aldosterone system, in contrast to β blockers and thiazides. Current users of both ACE-Is/ARBs and

CCBs were excluded from the head-to-head comparison of these drugs.

In our second analysis, we examined the outcomes of former ACE-I/ARB users (prescription filled 91 to 365 days before index date) versus nonusers to address potential uncontrolled confounding by indication.

Potential Confounders

We included a range of variables potentially associated both with cardiovascular drug use and with the outcomes of interest. Age and sex were obtained from the population registry.²⁴ We included information on coexisting conditions requiring inpatient or outpatient hospital contact within 10 years before the index admission from the patient registry (see Table 1 and Table S1 for included codes).²⁵ Prescriptions for important concurrent medications filled within 90 days before admission were also included.²⁷ Finally, as socioeconomic markers, we included data on marital status and on urban versus rural residence.

Statistical Analysis

Patient characteristics were tabulated according to exposure groups before and after propensity score (PS-) weighting. The PS, which measures the probability of being exposed, was estimated using a logistic

Table 1. Characteristics of Current Users of ACE-Is or ARBs and CCBs Admitted With Influenza or Pneumonia, Overall and After PS-Weighting

	Overall Cohort			PS-Weighted Cohort		
	Current ACE-I/ ARB Use, N (%)	Current CCB Use, N (%)	SD	Current ACE-I/ ARB Use, N (%)	Current CCB Use*, N (%)	SD
No. of patients	100 278 (72.5)	37 961 (27.5)		100 278 (50.2)	99 625 (49.8)	
Age, median (Q1–Q3), y	76.9 (68.5–83.9)	78.8 (70.2–85.8)	0.21	76.9 (68.5–83.9)	77.5 (69.1–84.3)	0.07
Male	53 833 (53.7)	18 500 (48.7)	0.14	53 833 (53.7)	51 740 (51.9)	0.05
Coexisting conditions (within prior 10 y)						
Hospital-diagnosed hypertension	51 716 (51.6)	21 587 (56.9)	0.15	51 716 (51.6)	54 522 (54.7)	0.09
Previous myocardial infarction	13 449 (13.4)	3335 (8.8)	0.21	13 449 (13.4)	13 416 (13.5)	0.00
Diagnosis of stable angina pectoris	18 861 (18.8)	6440 (17.0)	0.07	18 861 (18.8)	18 714 (18.8)	0.00
Heart failure	26 518 (26.4)	4330 (11.4)	0.55	26 518 (26.4)	26 546 (26.6)	0.01
Stroke	14 843 (14.8)	6323 (16.7)	0.07	14 843 (14.8)	15 759 (15.8)	0.04
Atrial fibrillation/flutter	25 816 (25.7)	6925 (18.2)	0.26	25 816 (25.7)	26 164 (26.3)	0.02
Heart valve disease	9678 (9.7)	3329 (8.8)	0.04	9678 (9.7)	9991 (10.0)	0.02
Venous thromboembolism	5381 (5.4)	1965 (5.2)	0.01	5381 (5.4)	5710 (5.7)	0.02
Diabetes mellitus	29 098 (29.0)	8036 (21.2)	0.26	29 098 (29.0)	30 230 (30.3)	0.04
Chronic pulmonary disease	30 900 (30.8)	11 396 (30.0)	0.02	30 900 (30.8)	31 262 (31.4)	0.02
Renal disease	9404 (9.4)	5708 (15.0)	0.25	9404 (9.4)	10 275 (10.3)	0.04
End-stage renal disease	1417 (1.4)	1610 (4.2)	0.24	1417 (1.4)	1574 (1.6)	0.02
Liver disease	1681 (1.7)	759 (2.0)	0.03	1681 (1.7)	1696 (1.7)	0.00
Dementia	5735 (5.7)	2716 (7.2)	0.08	5735 (5.7)	5901 (5.9)	0.01
Cancer	18 573 (18.5)	7784 (20.5)	0.07	18 573 (18.5)	18 288 (18.4)	0.01
Metastatic cancer	2834 (2.8)	1312 (3.5)	0.05	2834 (2.8)	2726 (2.7)	0.01
Peptic ulcer disease	6523 (6.5)	2824 (7.4)	0.05	6523 (6.5)	6777 (6.8)	0.02
Rheumatoid arthritis or connective tissue disease	6562 (6.5)	2697 (7.1)	0.03	6562 (6.5)	6595 (6.6)	0.00
Comedication (prescription within 90 d)						
Total number of antihypertensive drugs†						
1	41 998 (41.9)	21 008 (55.3)	0.38	41 998 (41.9)	42 571 (42.7)	0.02
2	48 637 (48.5)	14 472 (38.1)	0.30	48 637 (48.5)	47 098 (47.3)	0.03
3	9352 (9.3)	2421 (6.4)	0.16	9352 (9.3)	9618 (9.7)	0.02
4	291 (0.3)	60 (0.2)	0.04	291 (0.3)	339 (0.3)	0.01
Thiazides	30 954 (30.9)	6788 (17.9)	0.43	30 954 (30.9)	32 095 (32.2)	0.04
β Blockers	35 525 (35.4)	11 735 (30.9)	0.14	35 525 (35.4)	33 406 (33.5)	0.06
Other antihypertensive drugs	1735 (1.7)	971 (2.6)	0.08	1735 (1.7)	1849 (1.9)	0.01
Statins	37 363 (37.3)	11 547 (30.4)	0.21	37 363 (37.3)	37 279 (37.4)	0.00
Aspirin	34 140 (34.0)	12 295 (32.4)	0.05	34 140 (34.0)	34 304 (34.4)	0.01
Loop diuretics	34 667 (34.6)	11 574 (30.5)	0.12	34 667 (34.6)	35 103 (35.2)	0.02
Immunosuppressants	1359 (1.4)	521 (1.4)	0.00	1359 (1.4)	1279 (1.3)	0.01
Glucocorticoids	15 050 (15.0)	6081 (16.0)	0.04	15 050 (15.0)	15 310 (15.4)	0.01
NSAIDs	12 334 (12.3)	4653 (12.3)	0.00	12 334 (12.3)	12 231 (12.3)	0.00
Opioids	27 563 (27.5)	11 423 (30.1)	0.08	27 563 (27.5)	28 122 (28.2)	0.02
Vitamin K antagonists	12 164 (12.1)	2863 (7.5)	0.22	12 164 (12.1)	11 842 (11.9)	0.01
Proton pump inhibitors	30 277 (30.2)	12 954 (34.1)	0.12	30 277 (30.2)	30 906 (31.0)	0.03
Antidepressants	22 736 (22.7)	9793 (25.8)	0.10	22 736 (22.7)	23 337 (23.4)	0.03

(Continued)

Table 1. Continued

	Overall Cohort			PS-Weighted Cohort		
	Current ACE-I/ ARB Use, N (%)	Current CCB Use, N (%)	SD	Current ACE-I/ ARB Use, N (%)	Current CCB Use*, N (%)	SD
Hypnotics/sedatives	15 720 (15.7)	6517 (17.2)	0.06	15 720 (15.7)	15 976 (16.0)	0.01
Antipsychotics	5508 (5.5)	2551 (6.7)	0.07	5508 (5.5)	5433 (5.5)	0.00
Antibiotics (prescription within 10 d)	26 448 (26.4)	9973 (26.3)	0.00	26 448 (26.4)	26 235 (26.3)	0.00
Antivirals (prescription within 10 d)	226 (0.2)	84 (0.2)	0.00	226 (0.2)	194 (0.2)	0.01
Lifestyle and social factors						
Markers of smoking	52 541 (52.4)	19 033 (50.1)	0.06	52 541 (52.4)	52 447 (52.6)	0.01
Obesity	10 262 (10.2)	2719 (7.2)	0.15	10 262 (10.2)	10 785 (10.8)	0.03
Alcoholism	6107 (6.1)	2381 (6.3)	0.01	6107 (6.1)	5925 (5.9)	0.01
Marital status						
Widow	31 850 (31.8)	13 837 (36.5)	0.14	31 850 (31.8)	33 295 (33.4)	0.05
Divorced	14 243 (14.2)	5368 (14.1)	0.00	14 243 (14.2)	14 118 (14.2)	0.00
Married	46 171 (46.0)	15 841 (41.7)	0.12	46 171 (46.0)	44 607 (44.8)	0.04
Unmarried	8014 (8.0)	2915 (7.7)	0.02	8014 (8.0)	7604 (7.6)	0.02
Urban residence	34 592 (34.5)	12 629 (33.3)	0.04	34 592 (34.5)	34 848 (35.0)	0.01

ACE-Is indicates angiotensin-converting enzyme inhibitors; ARBs, angiotensin receptor blockers; CCBs, calcium channel blockers; PS, propensity score; and SD, standardized difference.

*Pseudopopulation of current CCB users weighted to the PS distribution of current ACE-I/ARB users.

†Number of antihypertensive drugs including the exposure of interest (ACE-Is/ARBs or CCBs, thiazides, β blockers, and other (range from 1 to 4 because patients using both ACE-I/ARBs and CCBs are not included).

regression model, including calendar time and all covariates listed in Table 1. We used PS-weighting to generate a pseudopopulation of relevant comparisons (eg, CCB users or ACE-I/ARB nonusers) that resembled the number and covariate distribution of ACE-I/ARB users. As we were interested in the average treatment effect in the treated, we applied PS-weighting using average treatment effect in the treated weights to make the number and covariate distribution in the comparison groups resemble that of the ACE-I/ARB users. Overlap in PS distributions was checked before weighting and found sufficient. Covariate balance was assessed by standardized differences, empirical cumulative distribution functions for continuous variables (age and index), and by PS-weight percentiles. Overall, covariate balance was deemed acceptable, although there was some imbalance in small subgroups as reflected by high weights and standardized differences.

Follow-up started on the date of hospital contact with influenza/pneumonia and continued until the specific outcome of interest, emigration, or up to 30 days, whichever occurred first. The 30-day risk of death and ICU admission was computed and plotted, both crude and PS-weighted. Risk differences (RDs) were computed for all outcomes by subtracting PS-weighted risks. Risk ratios (RRs) were estimated as the ratio of PS-weighted risk estimates. All estimates were

presented with 95% CIs obtained through bootstrapping with 200 bootstrap samples.

Additional analyses were performed to examine the robustness of our findings.

First, we changed the exposure definition to make a head-to-head comparison between ACE-I/ARB and β blockers and thiazides, respectively. Second, we compared monotherapy with ACE-I/ARB with CCB monotherapy. Third, analyses were repeated using only the primary (first-listed) diagnoses of influenza or pneumonia. Fourth, analyses were stratified by age at the index date (18–65 years and >65 years). Fifth, analyses were repeated according to potential underlying indications for treatment including patients with renal disease, with congestive heart failure, with ischemic heart disease (myocardial infarction or stable angina pectoris), with diabetes mellitus, and without any of these comorbidities, and in patients without any of these comorbidities who had a hospital diagnosis of hypertension. Sixth, we repeated the analyses restricted to patients currently using more than 1 antihypertensive medication (polytherapy). Finally, we stratified by hospital versus community-acquired pneumonia defined as no hospital contract within 3 to 30 days before study inclusion.

All statistical analyses were performed using SAS version 9.4 (SAS Institute, Cary, NC).

RESULTS

The final study cohort included 568 019 adult Danish residents hospitalized for influenza or pneumonia (Figure 1): 100 278 (17.7%) were current ACE-I/ARB users, 37 961 (6.7%) were current CCB users, and 33 155 (5.8%) were current users of both. There were 9413 admissions for influenza and 518 296 for pneumonia with bacterial or unspecified pathogen. Of the overall cohort of influenza/pneumonia, 454 303 (79.8%) were community-acquired and 114 716 (20.2%) were hospital-acquired.

A total of 42 827 hospitalizations included admission to the ICU; for most of these patients, ICU transferal happened early (median of 1 day, 25th–75th percentiles: 0–5 days) after first hospital admission. A total of 76 762 died within 30 days. Patient characteristics of the final study cohort are provided in Table S2 overall, and by death within 30 days and ICU admission.

Descriptive Characteristics of ACE-I/ARB and CCB Users

Median age was almost similar in ACE-I/ARB and CCB users (76.9 versus 78.8 years). There were slightly

more men among ACE-I/ARB users than among CCB users (53.7% versus 48.7%). ACE-I/ARB users had a higher prevalence of most cardiovascular diseases, including heart failure, myocardial infarction, and diabetes mellitus. In contrast, hypertension and renal disease were less frequent in ACE-I/ARB users than in CCB users (Table 1). Comedication with most cardiovascular medications, including other antihypertensive drugs, was more frequent in ACE-I/ARB users. In both groups, 26% of patients had received antibiotics within 10 days prior to hospital admission. Markers of smoking and alcohol-related disorders were equally prevalent in both groups; obesity was more common in ACE-I/ARB users.

After PS-weighting of CCB users, treatment groups were well-balanced on all measured covariates, with absolute standardized differences for all covariates decreasing from 0.00 to 0.55 before PS-balancing to <0.10 (Table 1).

Outcomes in ACE-I/ARB Versus CCB Users

Table 2 shows the number of outcome events, risks, RDs, and RRs after PS-weighting of CCB users. The

Table 2. Outcomes in Current Users of ACE-Is or ARBs Compared With CCBs, Adjusted by PS-Weighting and Stratified by Influenza and Pneumonia With Bacterial or Unspecified Pathogen

Population	Event	ACE-Is/ARBs		CCBs		Risk Difference* % (95% CI) vs CCBs	Risk Ratio* (95% CI) vs CCBs
		Events/at Risk	Risk %	Events/at Risk*	Risk* %		
Any influenza or pneumonia	30-d mortality	13 940/100 278	13.9%	14 412/99 625	14.5%	−0.6 (−1.0 to −0.1)	0.96 (0.93–0.99)
	ICU admission	7993/100 278	8.0%	9558/99 625	9.6%	−1.6 (−2.0 to −1.2)	0.83 (0.80–0.87)
	ICU+MV	4218/100 278	4.2%	5196/99 625	5.2%	−1.0 (−1.3 to −0.7)	0.81 (0.76–0.86)
	ICU+NIV	3039/100 278	3.0%	4132/99 625	4.1%	−1.1 (−1.4 to −0.8)	0.73 (0.68–0.79)
	ICU+inotropes/vasopressors	3825/100 278	3.8%	3877/99 625	3.9%	−0.1 (−0.3 to 0.2)	0.98 (0.92–1.05)
	D-AKI	965/98 861	1.0%	1296/98 534	1.3%	−0.3 (−0.5 to −0.1)	0.74 (0.64–0.86)
Influenza	30-d mortality	82/1565	5.2%	60/1516	3.9%	1.3 (−1.2 to 3.8)	1.33 (0.69–2.55)
	ICU admission	129/1565	8.2%	146/1516	9.6%	−1.4 (−5.7 to 3.0)	0.86 (0.53–1.39)
	ICU+MV	70/1565	4.5%	70/1516	4.6%	−0.2 (−2.9 to 2.6)	0.96 (0.52–1.80)
	ICU+NIV	63/1565	4.0%	55/1516	3.6%	0.4 (−1.6 to 2.3)	1.11 (0.65–1.88)
	ICU+inotropes/vasopressors	61/1565	3.9%	55/1516	3.6%	0.3 (−2.4 to 2.9)	1.07 (0.51–2.25)
	D-AKI	15/1514	1.0%	<5/1504	0.3%	0.7 (0.1–1.3)	3.40 (0.96–12.02)
Pneumonia with bacterial or unspecified pathogen†	30-d mortality	13 140/93 193	14.1%	13 572/92 542	14.7%	−0.6 (−1.1 to −0.0)	0.96 (0.93–1.00)
	ICU admission	7456/93 193	8.0%	8912/92 542	9.6%	−1.6 (−2.1 to −1.2)	0.83 (0.79–0.87)
	ICU+MV	3918/93 193	4.2%	4788/92 542	5.2%	−1.0 (−1.3 to −0.7)	0.81 (0.76–0.87)
	ICU+NIV	2839/93 193	3.0%	3890/92 542	4.2%	−1.2 (−1.5 to −0.9)	0.72 (0.67–0.78)
	ICU+inotropes/vasopressors	3567/93 193	3.8%	3587/92 542	3.9%	−0.0 (−0.3 to 0.2)	0.99 (0.92–1.07)
	D-AKI	886/91 899	1.0%	1185/91 538	1.3%	−0.3 (−0.5 to −0.2)	0.74 (0.65–0.86)

ACE-Is indicates angiotensin-converting enzyme inhibitors; ARBs, angiotensin receptor blockers; CCBs, calcium channel blockers; D-AKI, dialysis-treated acute kidney injury; ICU, intensive care unit; MV, mechanical ventilation; NIV, noninvasive ventilation; and PS, propensity score.

*Pseudopopulation of current CCB users weighted to the PS distribution of current ACE-I/ARB users.

†Not including viral pneumonia and influenza without proven influenza virus.

crude estimates are provided in Table 3. The cumulative incidence (risk) plots before (crude-) and after PS-weighting (adjusted) are given in Figure 2A and 2B.

Among all patients with influenza or pneumonia, 30-day mortality was 13.9% in ACE-I/ARB users and 14.5% in CCB users, with a corresponding RD of -0.6% (95% CI, -1.0 to -0.1) and a RR of 0.96 (95% CI, 0.93–0.99). The risk of ICU admission was 8.0% in ACE-I/ARB users and 9.6% in CCB users, corresponding to an RD of -1.6% (95% CI, -2.0 to -1.2) and an RR of 0.83 (95% CI, 0.80–0.87) for ACE-I/ARB users compared with CCB users. The estimates were similar for ICU admissions with need for mechanical ventilation, noninvasive ventilation, and dialysis-treated acute kidney injury. There was no difference in risk of ICU admission including treatment with inotropes/vasopressors (RD, -0.1% ; 95% CI, -0.3 to 0.2).

In the subgroup of patients diagnosed with influenza, 30-day mortality was 5.2% in ACE-I/ARB users and 3.9% in CCB users (RD, 1.3%; 95% CI, -1.2 to 3.8 ; RR, 1.33, 95% CI, 0.69–2.55). The risk of ICU admission was 8.2% in ACE-I/ARB users and 9.6% in CCB users (RD, -1.4% ; 95% CI, -5.7 to 3.0 ; RR, 0.86; 95%,

CI, 0.53–1.39). Risk of ICU admission with need for mechanical ventilation was similar in ACE-I/ARB and CCB users (4.5% versus 4.6%).

Characteristics and Outcomes in Current Users of ACE-Is/ARBs Compared With Nonusers

The patient characteristics of all current ACE-I/ARB users and nonusers were reasonably balanced after PS-weighting, with only a few standardized differences above 0.10 (Table 4).

ACE-I/ARB users had lower 30-day mortality than nonusers (13.5% versus 15.9%; Table 5). The corresponding RD was -2.4% (95% CI, -2.8 to -2.0) and the RR was 0.85 (95% CI, 0.83–0.87). The risk of ICU admission was similar among users and nonusers (8.4% versus 8.1%; RD, 0.4%; 95% CI, 0.0–0.7; RR, 1.04; 95% CI, 1.00–1.09). When compared with nonusers, former ACE-I/ARB users did not have increased mortality, but they did have a decreased risk of ICU admission (Figure 3). Crude estimates are provided in Table 6.

Table 3. Crude Outcomes in Current Users of ACE-Is or ARBs Compared With CCBs, Overall and Stratified by Influenza and Pneumonia With Bacterial or Unspecified Pathogen

Population	Event	ACE-Is/ARBs		CCBs		Risk Difference* % (95% CI) vs CCBs	Risk Ratio* (95% CI) vs CCBs
		Events/At Risk	Risk %	Events/At Risk*	Risk* %		
Any influenza or pneumonia	30-d mortality	13 940/100 278	13.9	6016/37 961	15.8	-1.9 (-2.4 to -1.5)	0.88 (0.85–0.90)
	ICU admission	7993/100 278	8.0	3321/37 961	8.7	-0.8 (-1.1 to -0.5)	0.91 (0.88–0.94)
	ICU+MV	4218/100 278	4.2	1753/37 961	4.6	-0.4 (-0.6 to -0.2)	0.91 (0.87–0.95)
	ICU+NIV	3039/100 278	3.0	1468/37 961	3.9	-0.8 (-1.0 to -0.6)	0.78 (0.74–0.83)
	ICU+inotropes/vasopressors	3825/100 278	3.8	1322/37 961	3.5	0.3 (0.1–0.5)	1.10 (1.04–1.16)
	D-AKI	965/98 861	1.0	438/36 351	1.2	-0.2 (-0.4 to -0.1)	0.81 (0.72–0.92)
Influenza	30-d mortality	82/1565	5.2	25/526	4.8	0.5 (-1.6 to 2.5)	1.10 (0.71–1.71)
	ICU admission	129/1565	8.2	44/526	8.4	-0.1 (-2.8 to 2.6)	0.99 (0.70–1.38)
	ICU+MV	70/1565	4.5	24/526	4.6	-0.1 (-2.1 to 1.9)	0.98 (0.62–1.56)
	ICU+NIV	63/1565	4.0	28/526	5.3	-1.3 (-3.5 to 0.9)	0.76 (0.47–1.21)
	ICU+inotropes/vasopressors	61/1565	3.9	20/526	3.8	0.1 (-1.8 to 2.0)	1.03 (0.62–1.69)
	D-AKI	15/1514	1.0	<5/449	0.7	0.3 (-0.5 to 1.2)	1.48 (0.45–4.84)
Pneumonia with bacterial or unspecified pathogen	30-d mortality	13 140/93 193	14.1	5683/35 426	16.0	-1.9 (-2.4 to -1.5)	0.88 (0.85–0.91)
	ICU admission	7456/93 193	8.0	3123/35 426	8.8	-0.8 (-1.2 to -0.5)	0.91 (0.87–0.95)
	ICU+MV	3918/93 193	4.2	1640/35 426	4.6	-0.4 (-0.7 to -0.2)	0.91 (0.86–0.96)
	ICU+NIV	2839/93 193	3.0	1389/35 426	3.9	-0.9 (-1.1 to -0.7)	0.78 (0.73–0.83)
	ICU+inotropes/vasopressors	3567/93 193	3.8	1240/35 426	3.5	0.3 (0.1–0.6)	1.09 (1.02–1.17)
	D-AKI	886/91 899	1.0	407/33 983	1.2	-0.2 (-0.3 to -0.1)	0.80 (0.73–0.89)

ACE-Is indicates angiotensin-converting enzyme inhibitors; ARBs, angiotensin receptor blockers; CCBs, calcium channel blockers; D-AKI, dialysis-treated acute kidney injury; ICU, intensive care unit; MV, mechanical ventilation; NIV, noninvasive ventilation; and PS, propensity score.

*Pseudopopulation of current CCB users weighted to the PS distribution of current ACE-I/ARB users.

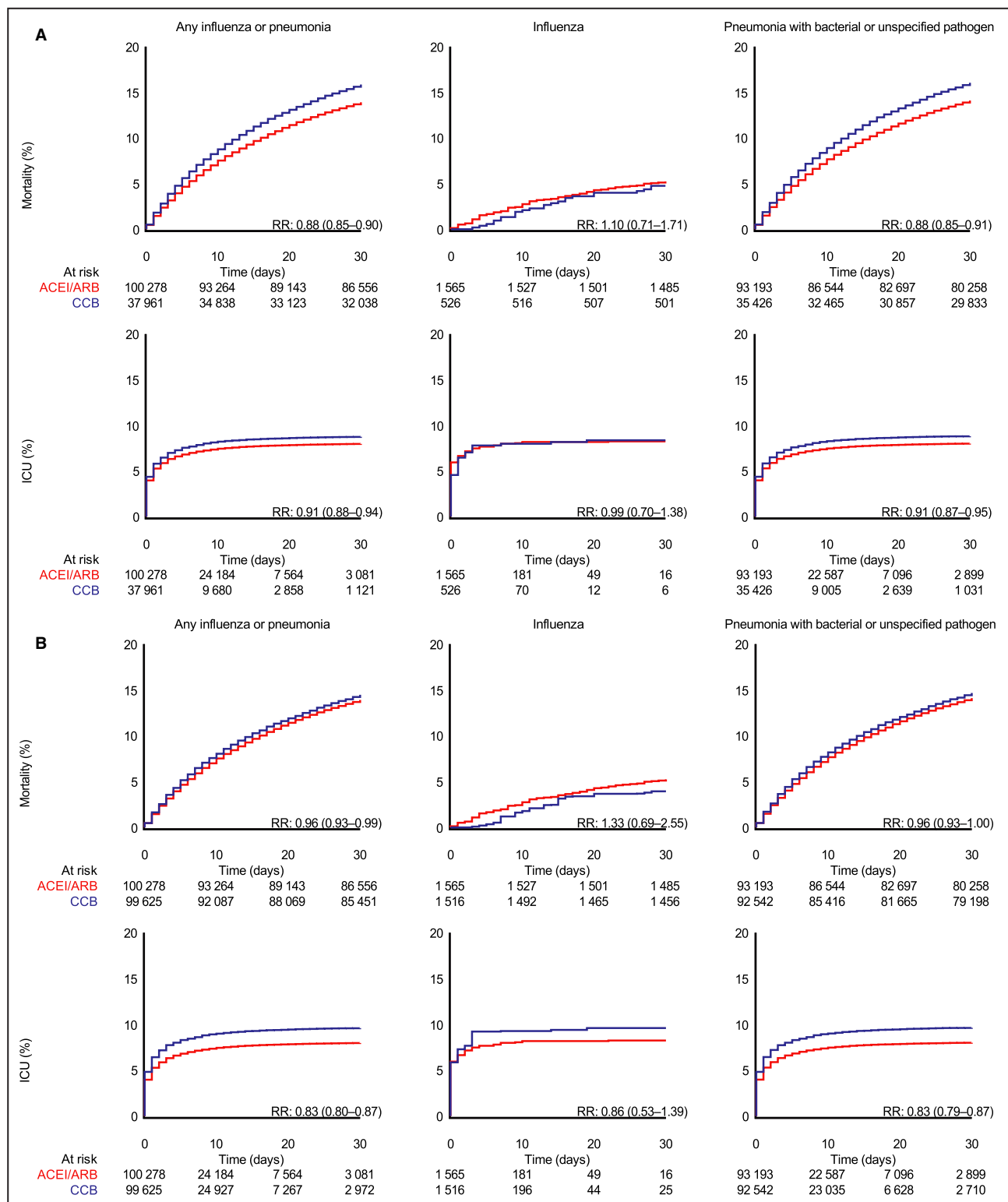


Figure 2. Crude (A) and propensity score-weighted (B) 30-day cumulative incidence (risk) and relative risk (RR) of death and intensive care unit (ICU) admission in patients with influenza or pneumonia, with only influenza, and with pneumonia with bacterial or unspecified pathogen.

ACEI indicates angiotensin-converting enzyme inhibitor; ARB, angiotensin receptor blocker; CCB, calcium channel blocker.

Table 4. Characteristics of Current and Nonusers of ACE-Is or ARBs, Overall and After PS-Weighting

	Overall Cohort			PS-Weighted Cohort		
	Current Use, N (%)	Nonuse, N (%)	SD	Current Use, N (%)	Nonuse*, N (%)	SD
No. of patients	133 433 (25.6)	388 790 (74.4)		133 433 (46.6)	153 032 (53.4)	
Age, median (Q1–Q3), y	76.8 (68.4–83.9)	71.0 (55.5–82.2)	0.72	76.8 (68.4–83.9)	77.9 (70.0–84.5)	0.14
Male	71 441 (53.5)	193 862 (49.9)	0.10	71 441 (53.5)	80 274 (52.5)	0.03
Coexisting conditions (within prior 10 y)						
Hospital-diagnosed hypertension	73 445 (55.0)	69 624 (17.9)	1.18	73 445 (55.0)	96 194 (62.9)	0.23
Previous myocardial infarction	16 679 (12.5)	17 563 (4.5)	0.41	16 679 (12.5)	22 901 (15.0)	0.10
Diagnosis of stable angina pectoris	24 532 (18.4)	35 356 (9.1)	0.39	24 532 (18.4)	31 467 (20.6)	0.08
Heart failure	31 094 (23.3)	29 366 (7.6)	0.63	31 094 (23.3)	44 098 (28.8)	0.18
Stroke	20 229 (15.2)	38 078 (9.8)	0.23	20 229 (15.2)	25 042 (16.4)	0.05
Atrial fibrillation/flutter	32 077 (24.0)	51 014 (13.1)	0.40	32 077 (24.0)	40 708 (26.6)	0.08
Heart valve disease	12 482 (9.4)	17 585 (4.5)	0.27	12 482 (9.4)	17 586 (11.5)	0.10
Venous thromboembolism	6780 (5.1)	19 016 (4.9)	0.01	6780 (5.1)	8142 (5.3)	0.02
Diabetes mellitus	40 513 (30.4)	41 969 (10.8)	0.71	40 513 (30.4)	51 830 (33.9)	0.11
Chronic pulmonary disease	39 469 (29.6)	104 818 (27.0)	0.08	39 469 (29.6)	47 524 (31.1)	0.05
Renal disease	14 090 (10.6)	19 586 (5.0)	0.29	14 090 (10.6)	20 715 (13.5)	0.13
End-stage renal disease	2558 (1.9)	4865 (1.3)	0.08	2558 (1.9)	3756 (2.5)	0.05
Liver disease	2144 (1.6)	12 069 (3.1)	0.14	2144 (1.6)	2327 (1.5)	0.01
Dementia	7375 (5.5)	25 108 (6.5)	0.06	7375 (5.5)	8408 (5.5)	0.00
Cancer	24 429 (18.3)	71 800 (18.5)	0.01	24 429 (18.3)	27 422 (17.9)	0.01
Metastatic cancer	3823 (2.9)	12 863 (3.3)	0.04	3823 (2.9)	4070 (2.7)	0.02
Peptic ulcer disease	8495 (6.4)	20 797 (5.3)	0.06	8495 (6.4)	10 630 (6.9)	0.03
Rheumatoid arthritis or connective tissue disease	8593 (6.4)	20 944 (5.4)	0.06	8593 (6.4)	10 141 (6.6)	0.01
Comedication (prescription within 90 d)						
CCBs	33 155 (24.8)	30 720 (7.9)	0.67	33 155 (24.8)	47 023 (30.7)	0.19
Thiazides	44 645 (33.5)	31 089 (8.0)	0.94	44 645 (33.5)	57 991 (37.9)	0.13
β Blockers	48 363 (36.2)	50 612 (13.0)	0.79	48 363 (36.2)	64 996 (42.5)	0.18
Other antihypertensive drugs	3304 (2.5)	2165 (0.6)	0.22	3304 (2.5)	5179 (3.4)	0.08
Statins	51 633 (38.7)	49 818 (12.8)	0.88	51 633 (38.7)	67 673 (44.2)	0.16
Aspirin	46 492 (34.8)	62 983 (16.2)	0.62	46 492 (34.8)	60 158 (39.3)	0.13
Loop diuretics	44 817 (33.6)	68 607 (17.6)	0.53	44 817 (33.6)	58 864 (38.5)	0.14
Immunosuppressants	1754 (1.3)	4468 (1.1)	0.02	1754 (1.3)	1979 (1.3)	0.00

(Continued)

Table 4. Continued

	Overall Cohort			PS-Weighted Cohort		
	Current Use, N (%)	Nonuse, N (%)	SD	Current Use, N (%)	Nonuse*, N (%)	SD
Glucocorticoids	19 404 (14.5)	52 371 (13.5)	0.04	19 404 (14.5)	23 187 (15.2)	0.02
NSAIDs	16 746 (12.6)	46 738 (12.0)	0.02	16 746 (12.6)	19 235 (12.6)	0.00
Opioids	36 636 (27.5)	94 717 (24.4)	0.10	36 636 (27.5)	43 555 (28.5)	0.03
Vitamin K antagonists	15 165 (11.4)	18 620 (4.8)	0.34	15 165 (11.4)	19 818 (13.0)	0.07
Proton pump inhibitors	40 862 (30.6)	92 464 (23.8)	0.22	40 862 (30.6)	50 863 (33.2)	0.08
Antidepressants	30 223 (22.7)	81 315 (20.9)	0.06	30 223 (22.7)	36 335 (23.7)	0.04
Hypnotics/sedatives	20 601 (15.4)	51 308 (13.2)	0.09	20 601 (15.4)	24 605 (16.1)	0.02
Antipsychotics	7155 (5.4)	29 802 (7.7)	0.13	7155 (5.4)	7880 (5.1)	0.01
Antibiotics (prescription within 10 d)	35 169 (26.4)	113 795 (29.3)	0.09	35 169 (26.4)	39 545 (25.8)	0.02
Antivirals (prescription within 10 d)	289 (0.2)	1160 (0.3)	0.02	289 (0.2)	326 (0.2)	0.00
Lifestyle and social factors						
Markers of smoking	68 378 (51.2)	187 502 (48.2)	0.09	68 378 (51.2)	80 872 (52.8)	0.05
Obesity	13 666 (10.2)	25 742 (6.6)	0.18	13 666 (10.2)	17 001 (11.1)	0.04
Alcoholism	7966 (6.0)	34 773 (8.9)	0.16	7966 (6.0)	8522 (5.6)	0.02
Marital status						
Widow	42 492 (31.8)	96 406 (24.8)	0.22	42 492 (31.8)	52 400 (34.2)	0.07
Divorced	18 773 (14.1)	60 204 (15.5)	0.06	18 773 (14.1)	20 810 (13.6)	0.02
Married	61 321 (46.0)	163 218 (42.0)	0.11	61 321 (46.0)	68 524 (44.8)	0.03
Unmarried	10 847 (8.1)	68 962 (17.7)	0.41	10 847 (8.1)	11 297 (7.4)	0.04
Urban residence	45 019 (33.7)	146 919 (37.8)	0.12	45 019 (33.7)	51 920 (33.9)	0.01

ACE-Is indicates angiotensin-converting enzyme inhibitors; ARBs, angiotensin receptor blockers; CCBs, calcium channel blockers; PS, propensity score; and SD, standardized difference.

*Pseudopopulation of nonusers weighted to the PS distribution of current ACE-I/ARB users.

Table 5. Outcomes in Current Users of ACE-Is or ARBs Compared With Nonusers, Adjusted by PS-Weighting and Stratified by Influenza and Pneumonia With Bacterial or Unspecified Pathogen

Population	Event	Current ACE-I/ARB Use		ACE-I/ARB Nonuse		Risk Difference % (95% CI) vs Nonuse*	Risk Ratio (95% CI) vs Nonuse*
		Events/At Risk	Risk %	Events/At Risk*	Risk* %		
Any influenza or pneumonia	30-d mortality	18 017/133 433	13.5%	24 273/153 032	15.9%	−2.4 (−2.8 to −2.0)	0.85 (0.83–0.87)
	ICU admission	11 225/133 433	8.4%	12 332/153 032	8.1%	0.4 (0.0–0.7)	1.04 (1.00–1.09)
	ICU+MV	5965/133 433	4.5%	6600/153 032	4.3%	0.2 (−0.1 to 0.4)	1.04 (0.98–1.10)
	ICU+NIV	4424/133 433	3.3%	5219/153 032	3.4%	−0.1 (−0.3 to 0.1)	0.97 (0.91–1.04)
	ICU+inotropes/ vasopressors	5352/133 433	4.0%	5294/153 032	3.5%	0.6 (0.3–0.8)	1.16 (1.08–1.24)
	D-AKI	1455/130 875	1.1%	1617/150 516	1.1%	0.0 (−0.1 to 0.2)	1.03 (0.89–1.20)
Influenza	30-d mortality	110/2110	5.2%	182/2447	7.4%	−2.2 (−5.0 to 0.5)	0.70 (0.47–1.05)
	ICU admission	191/2110	9.1%	212/2447	8.7%	0.4 (−1.9 to 2.7)	1.04 (0.80–1.37)
	ICU+MV	118/2110	5.6%	109/2447	4.4%	1.1 (−0.5 to 2.8)	1.26 (0.89–1.78)
	ICU+NIV	94/2110	4.5%	99/2447	4.1%	0.4 (−1.3 to 2.1)	1.10 (0.74–1.63)
	ICU+inotropes/ vasopressors	103/2110	4.9%	93/2447	3.8%	1.1 (−0.3 to 2.5)	1.29 (0.91–1.82)
	D-AKI	22/2014	1.1%	30/2363	1.3%	−0.2 (−1.3 to 0.9)	0.86 (0.36–2.07)
Pneumonia with bacterial or unspecified pathogen†	30-d mortality	16 979/124 054	13.7%	22 644/141 687	16.0%	−2.3 (−2.7 to −1.9)	0.86 (0.83–0.88)
	ICU admission	10 482/124 054	8.4%	11 361/141 687	8.0%	0.4 (0.1–0.8)	1.05 (1.01–1.10)
	ICU+MV	5529/124 054	4.5%	5990/141 687	4.2%	0.2 (−0.0 to 0.5)	1.05 (0.99–1.12)
	ICU+NIV	4151/124 054	3.3%	4853/141 687	3.4%	−0.1 (−0.3 to 0.2)	0.98 (0.91–1.05)
	ICU+inotropes/ vasopressors	4973/124 054	4.0%	4817	3.4%	0.6 (0.4–0.9)	1.18 (1.10–1.26)
	D-AKI	1343/121 749	1.1%	1422	1.0%	0.1 (−0.0 to 0.2)	1.08 (0.95–1.23)

ACE-Is indicates angiotensin-converting enzyme inhibitors; ARBs, angiotensin receptor blockers; D-AKI, dialysis-treated acute kidney injury; ICU, intensive care unit; MV, mechanical ventilation; NIV, noninvasive ventilation; and PS, propensity score.

*Pseudopopulation of nonusers weighted to the PS distribution of current ACE-I/ARB users.

†Not including viral pneumonia and influenza without proven influenza virus.

Additional Analyses

The head-to-head comparisons of ACE-Is/ARBs with β blockers and thiazides, respectively, showed that 30-day mortality was also lowered in ACE-I/ARB users when compared with these other drugs, whereas there was no difference in risk of ICU admission (Figure 3).

ACE-I/ARB monotherapy users did not have increased mortality, but decreased absolute and relative risk of ICU admission when compared with CCB monotherapy (Figure 3).

Restriction to patients with a first-listed diagnosis of influenza or pneumonia reduced the number of current ACE-I/ARB users to 69 373 and current CCB users to 26 006. PS-weighted 30-day mortality was 11.3% in ACE-I/ARB users and 11.8% in CCB users. The corresponding RR was 0.96 (95% CI, 0.92–1.01). Relative risk of ICU admission was also similar to that obtained in the main analyses (RR, 0.80; 95% CI, 0.74–0.87; Figure 3). The subgroup analyses by age and coexisting conditions were overall robust and compatible with our main findings. In patients without any other conditions than hypertension, current ACE-I/ARB users had lower

absolute and relative risks of both death and ICU admission (Figure 3). Our findings were robust also when restricting to patients on more than one antihypertensive medication (polytherapy), and when stratifying by hospital- and community-acquired pneumonia (Figure 3).

DISCUSSION

In this cohort study of patients with influenza or pneumonia, we found that ACE-I/ARB users had no increased risk of ICU admissions and a slightly reduced mortality, after controlling for coexisting conditions and comedications. The findings were robust across various different exposure definitions, subgroups, and also when compared with other antihypertensive drugs. We observed reduced risks of both ICU admission and mortality in some subgroups of ACE-I/ARB users, including patients with hypertension and no other cardiometabolic conditions.

Our study extends findings from previous smaller studies of pneumonia mortality. Our observed

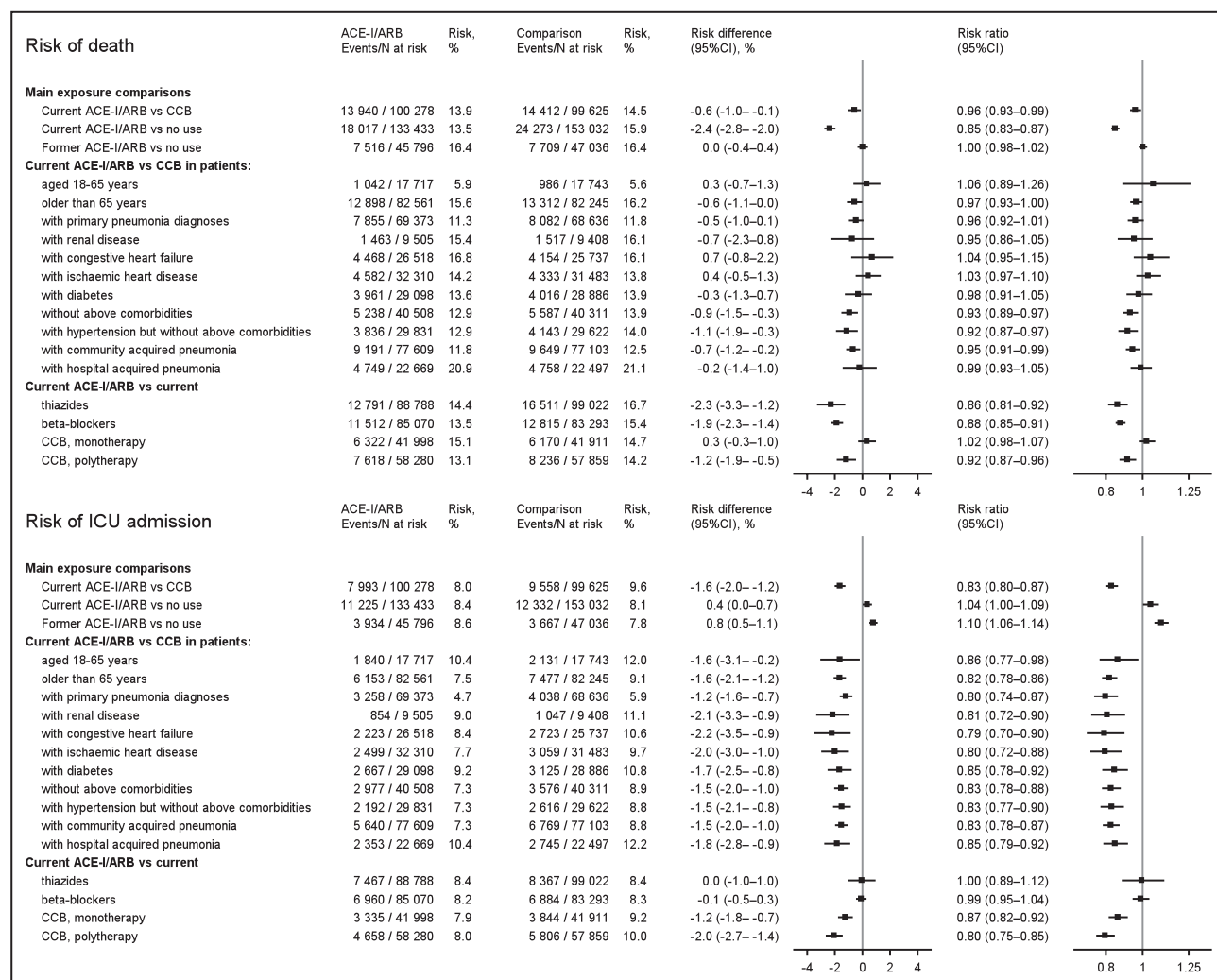


Figure 3. Thirty-day mortality and risk of intensive care unit (ICU) admission by different exposure definitions and subgroups. ACE-I indicates angiotensin-converting enzyme inhibitor; ARB, angiotensin receptor blocker; and CCB, calcium channel blocker.

associations were weaker than reported in previous studies.^{16–18} A previous meta-analysis of 3 trials and 4 observational studies with data on pneumonia-related mortality reported decreased odds for mortality in ACE-I users compared with nonusers (OR, 0.73; 95% CI, 0.58–0.92), but most of the studies examined were not designed to address this topic, as ACE-I was not their main exposure, and several studies mixed pneumonia risk and outcomes.¹⁶ In a later US study including 8652 pneumonia patients aged ≥ 65 years, ACE-I use prior to hospitalization also was associated with reduced 30-day mortality (adjusted OR, 0.80; 95% CI, 0.68–0.89).¹⁷ Another US study that examined the association between cardiovascular medication in 21 985 elderly patients hospitalized with pneumonia reported an adjusted OR for 90-day mortality of 0.82 (95% CI, 0.74–0.91) for ACE-I users and 0.58 (95% CI, 0.44–0.77) for ARB users.¹⁸

In contrast, a US study of patients hospitalized with mixed viral disease found that preadmission ACE-I use was associated with increased mortality (OR, 3.02; 95% CI, 1.30–7.01) and increased intubation rates among the 539 patients admitted with pneumonia.¹⁹ In that study, in-hospital ACE-I use was associated with substantially lowered mortality, which may be biased as the drug may only be continued during hospitalization in patients without severe illness.¹⁹ Such bias may also explain the lower mortality (OR, 0.37; 95% CI, 0.15–0.89) among in-hospital users of ACE-I/ARBs in a recent Chinese study of 1128 patients with COVID-19.²⁰ Another recent Chinese study of 1178 patients found no association between in-hospital use of ACE-I/ARBs and the severity and mortality of patients with COVID-19.²¹

The mechanism behind our findings is not clear. ACE2 expression, which is probably increased in

Table 6. Crude Outcomes in Current Versus Nonusers of ACE-Is or ARBs, Overall and Stratified by Influenza and Pneumonia With Bacterial or Unspecified Pathogen

Population	Event	ACE-I/ARB Use		Nonuse		Risk Difference % (95% CI) vs Nonuse	Risk Ratio (95% CI) vs Nonuse
		Events/At Risk	Risk %	Events/At risk†	Risk† %		
Any influenza or pneumonia	30-d mortality	18 017/133 433	13.5	51 229/388 790	13.2	0.3 (0.1–0.5)	1.02 (1.01–1.04)
	ICU admission	11 225/133 433	8.4	27 668/388 790	7.1	1.3 (1.1–1.5)	1.18 (1.16–1.21)
	ICU+MV	5965/133 433	4.5	15 300/388 790	3.9	0.5 (0.4–0.7)	1.14 (1.11–1.17)
	ICU+NIV	4424/133 433	3.3	10 224/388 790	2.6	0.7 (0.6–0.8)	1.26 (1.22–1.31)
	ICU+inotropes/ vasopressors	5352/133 433	4.0	11 547/388 790	3.0	1.0 (0.9–1.2)	1.35 (1.31–1.40)
	D-AKI	1455/130 875	1.1	2561/383 925	0.7	0.4 (0.4–0.5)	1.67 (1.55–1.79)
Influenza	30-d mortality	110/2110	5.2	296/6581	4.5	0.7 (–0.5 to 1.9)	1.16 (0.92–1.45)
	ICU admission	191/2110	9.1	497/6581	7.6	1.5 (0.0–3.0)	1.20 (1.01–1.42)
	ICU+MV	118/2110	5.6	336/6581	5.1	0.5 (–0.7 to 1.7)	1.10 (0.88–1.36)
	ICU+NIV	94/2110	4.5	228/6581	3.5	1.0 (–0.0 to 2.0)	1.29 (1.01–1.64)
	ICU+inotropes/ vasopressors	103/2110	4.9	282/6581	4.3	0.6 (–0.5 to 1.6)	1.14 (0.91–1.43)
	D-AKI	22/2014	1.1	78/6386	1.2	–0.1 (–0.6 to 0.4)	0.89 (0.58–1.38)
Pneumonia with bacterial or unspecified pathogen	30-d mortality	16 979/124 054	13.7	48 206/351 722	13.7	–0.0 (–0.2 to 0.2)	1.00 (0.98–1.02)
	ICU admission	10 482/124 054	8.4	25 667/351 722	7.3	1.2 (1.0–1.3)	1.16 (1.13–1.18)
	ICU+MV	5529/124 054	4.5	14 056/351 722	4.0	0.5 (0.3–0.6)	1.12 (1.08–1.15)
	ICU+NIV	4151/124 054	3.3	9518/351 722	2.7	0.6 (0.5–0.8)	1.24 (1.19–1.28)
	ICU+inotropes/ vasopressors	4973/124 054	4.0	10 632/351 722	3.0	1.0 (0.9–1.1)	1.33 (1.28–1.37)
	D-AKI	1343/121 749	1.1	2320/347 374	0.7	0.4 (0.4–0.5)	1.65 (1.54–1.77)

ACE-Is indicates angiotensin-converting enzyme inhibitors; ARBs, angiotensin receptor blockers; D-AKI, dialysis-treated acute kidney injury; ICU, intensive care unit; MV, mechanical ventilation; and NIV, noninvasive ventilation.

ACE-I/ARB-treated patients, may protect against the development of severe acute lung injury.^{13,28,29} In contrast, it has been suggested that the ACE-I/ARB-induced increase in cell-surface ACE2 expression may increase the risk and severity of severe acute respiratory syndrome-coronavirus and severe acute respiratory syndrome-coronavirus 2 specifically.¹³ The contradictions are addressed in planned trials on the impact of losartan on organ dysfunction and mortality in patients hospitalized with COVID-19 (ClinicalTrials.gov Identifier: NCT04312009 and NCT04328012).

Although the current study was conducted in Denmark's population-based hospital setting using validated registries with complete follow-up on all Danish residents, it also had limitations. Observational studies of drug effects have inherent methodological challenges, and our results should therefore be interpreted with caution. Ultimately, a randomized controlled trial would be needed to draw firm conclusions regarding ACE-I/ARB effects on ICU admission and mortality in patients with influenza or pneumonia.

Study inclusion relied on coding of influenza and pneumonia. Although some patients may not receive a diagnosis, we believe the restriction to physician-coded influenza and pneumonia discharge diagnoses meant that only patients with clinically relevant infections were

included. The positive predictive value of pneumonia diagnoses in the patient registry is 90%.³⁰ Of patients diagnosed with influenza, 66% had a positive influenza test (A. Pottegård, MSc, PhD, DMSc, unpublished data, 2020). Any selection bias should be minimal because follow-up was virtually complete, and different associations between included and nonincluded patients are not expected.

Medication use was assessed using prescriptions prior to hospitalization in a time window corresponding to the typical interval between medication dispensings.²⁷ Still, misclassification may occur if some patients had a sporadic use of drugs filled more than 90 days before hospitalization. Given the chronic use of the drugs included in the study, any misclassification should be minor and not associated with the outcome of interest. Any information bias is therefore expected to be towards null. We lacked in-hospital medication data to examine the impact of prescribed and discontinued drugs during follow-up.

Death is accurately recorded in the population registry with daily updates.²⁴ ICU admissions and treatments are also accurately recorded, as the patient registry has been used for financial reimbursement of hospitals, and for mandatory reporting to national quality of care databases during the study period.^{26,31} Use of ICU admission

as an outcome in observational prognostic studies is challenging. In clinical practice, ICU admission is offered to patients who are expected to have a clear prognostic benefit from invasive monitoring and treatment.³² In addition, the patients' quality of life and functional level at home and hospital capacity may influence the decision to admit a patient to the ICU. This may explain why ICU and mortality outcomes tended to go in opposite directions for some of the associations examined in our study.

Potential confounding by medical indication for drug treatment was handled by using an active comparator in the main analysis, by using PS-weighting including a large number of potential confounders, and by restriction to subgroups according to indication for treatment. We observed and accounted for a higher use of antihypertensive and other cardiovascular medications in ACE-I/ARB users in our analysis. The higher use may be explained by the higher prevalence of heart diseases observed with ACE-I/ARB use. For example, the higher prevalence of vitamin K antagonist use may be explained by the higher prevalence of atrial fibrillation in ACE-I/ARB users compared with CCB users. On the other hand, the prevalence of eg kidney disease or dementia was lower in ACE-I/ARB users than in CCB users, indicating cautious use of ACE-I/ARB among patients with kidney disease and more frailty among CCB users. This may have contributed to the lower unadjusted relative risk (RR=0.88) of death in ACE-I/ARB users compared with CCB-users, which attenuated after PS-weighting (RR=0.96).

Although cardiovascular and other diagnoses used in the study have documented high positive predictive values,^{20,33} we cannot entirely rule out that our findings of a potential beneficial effect of ACE-I/ARB use were influenced by unmeasured confounding by indication and contraindication. Healthy user bias is, however, an unlikely explanation of the findings as the captured lifestyle factors did not indicate any healthier lifestyle in ACE-I/ARB users compared with CCB users. Finally, although our study included more than 500 000 patients, precision of risk estimates was limited in some subgroups.

In conclusion, ACE-I/ARB users hospitalized with influenza or pneumonia had no increased risk of ICU admission and a lower mortality after controlling for confounding. Thus, our data support the current recommendations^{1,21} to avoid discontinuation of ACE-I/ARBs during the COVID-19 pandemic, unless future evidence contradicts our findings.

ARTICLE INFORMATION

Received April 29, 2020; accepted August 31, 2020.

Affiliations

From the Department of Clinical Epidemiology, Aarhus University Hospital, Aarhus, Denmark (C.F.C., U.H.-J., T.B.R., M.S., H.T.S., R.W.T.); Department of Infectious Diseases, Aalborg University Hospital, Aalborg, Denmark (J.B.);

Department of Infectious Diseases (O.S.S.); Department of Cardiology, (M.M., M.S.); and Department of Intensive Care, Aarhus University Hospital, Aarhus, Denmark (S.T.V.); Department of Clinical Medicine, Aarhus University, Aarhus, Denmark (S.T.V.); Department of Cardiology, Regional Hospital West Jutland, Herning, Denmark (M.S.); Clinical Pharmacology and Pharmacy, Department of Public Health, University of Southern Denmark, Odense, Denmark (A.P., L.C.L., M.R., J.H.); Department of Medical Evaluation and Biostatistics, Danish Medicines Agency, Copenhagen, Denmark (N.B.J., N.C.B.); and Center for Population Health Sciences, Stanford University, Stanford, CA (H.T.S.).

Sources of Funding

The study was funded by Aarhus University, Denmark. The funding source had no influence on the study.

Disclosures

Dr Christiansen, Dr Heide-Jørgensen, Dr Rasmussen, Dr Thomsen, and Dr Sørensen have not received any personal fees, grants, travel grants, or teaching grants from companies, but the Department of Clinical Epidemiology is involved in studies with funding from various companies as research grants to (and administered by) Aarhus University. None of these studies are related to the current study. Dr Reilev, Dr Lund, Dr Pottegård, and Dr Hallas have participated in industry-funded projects with money paid to their employer, University of Southern Denmark. None have received personal compensation of any kind, and none of these projects is related to the current study. The remaining authors have no disclosures to report.

Supplementary Materials

Tables S1–S2

Figure S1

REFERENCES

- Sanders JM, Monogue ML, Jodlowski TZ, Cutrell JB. Pharmacologic treatments for coronavirus disease 2019 (COVID-19): a review. *JAMA*. 2020;323:1824–1836.
- Fang L, Karakiulakis G, Roth M. Are patients with hypertension and diabetes mellitus at increased risk for COVID-19 infection? *Lancet Respir Med*. 2020;8:e21.
- Sommerstein R, Gräni C. Rapid response: Re: preventing a covid-19 pandemic: ACE inhibitors as a potential risk factor for fatal Covid-19. *BMJ*. 2020;368:m810. Website name: . Available at: [bmj.com https://www.bmj.com/content/368/bmj.M810/r-2](https://www.bmj.com/content/368/bmj.M810/r-2). Accessed August 14, 2020.
- Patel AB, Verma A. COVID-19 and angiotensin-converting enzyme inhibitors and angiotensin receptor blockers: what is the evidence? *JAMA*. 2020;323:1769–1770.
- Hoffmann M, Kleine-Weber H, Schroeder S, Kruger N, Herrler T, Erichsen S, Schiergens TS, Herrler G, Wu NH, Nitsche A, et al. SARS-CoV-2 cell entry depends on ACE2 and TMPRSS2 and is blocked by a clinically proven protease inhibitor. *Cell*. 2020;181:271–280.e8.
- Guan WJ, Ni ZY, Hu Y, Liang WH, Ou CQ, He JX, Liu L, Shan H, Lei CL, Hui DSC, et al. Clinical characteristics of coronavirus disease 2019 in China. *N Engl J Med*. 2020;382:1708–1720.
- Yang X, Yu Y, Xu J, Shu H, Xia J, Liu H, Wu Y, Zhang L, Yu Z, Fang M, et al. Clinical course and outcomes of critically ill patients with SARS-CoV-2 pneumonia in Wuhan, China: a single-centered, retrospective, observational study. *Lancet Respir Med*. 2020;8:475–481.
- Zhou F, Yu T, Du R, Fan G, Liu Y, Liu Z, Xiang J, Wang Y, Song B, Gu X, et al. Clinical course and risk factors for mortality of adult inpatients with COVID-19 in Wuhan, China: a retrospective cohort study. *Lancet*. 2020;395:1054–1062.
- Onder G, Rezza G, Brusaferro S. Case-fatality rate and characteristics of patients dying in relation to COVID-19 in Italy. *JAMA*. 2020;323:1775–1776.
- Arentz M, Yim E, Klaff L, Lokhandwala S, Riedo FX, Chong M, Lee M. Characteristics and outcomes of 21 critically ill patients with COVID-19 in Washington State. *JAMA*. 2020;323:1612–1614.
- Bhatraju PK, Ghassemieh BJ, Nichols M, Kim R, Jerome KR, Nalla AK, Greninger AL, Pipavath S, Wurfel MM, Evans L, et al. Covid-19 in critically ill patients in the Seattle region—case series. *N Engl J Med*. 2020;382:2012–2022.

12. Clerkin KJ, Fried JA, Raikhelkar J, Sayer G, Griffin JM, Masoumi A, Jain SS, Burkhoff D, Kumaraiah D, Rabbani L, et al. COVID-19 and cardiovascular disease. *Circulation*. 2020;141:1648–1655.
13. Vaduganathan M, Vardeny O, Michel T, McMurray JJV, Pfeffer MA, Solomon SD. Renin–angiotensin–aldosterone system inhibitors in patients with Covid-19. *N Engl J Med*. 2020;382:1653–1659.
14. Aronson JK, Ferner RE. Drugs and the renin-angiotensin system in covid-19. *BMJ*. 2020;369:m1313.
15. Sommerstein R, Kochen MM, Messerli FH, Grani C. Coronavirus disease 2019 (COVID-19): do angiotensin-converting enzyme inhibitors/angiotensin receptor blockers have a biphasic effect? *J Am Heart Assoc*. 2020;9:e016509. DOI: 10.1161/JAHA.120.016509.
16. Caldeira D, Alarcao J, Vaz-Carneiro A, Costa J. Risk of pneumonia associated with use of angiotensin converting enzyme inhibitors and angiotensin receptor blockers: systematic review and meta-analysis. *BMJ*. 2012;345:e4260.
17. Mortensen EM, Nakashima B, Cornell J, Copeland LA, Pugh MJ, Anzueto A, Good C, Restrepo MI, Downs JR, Frei CR, et al. Population-based study of statins, angiotensin II receptor blockers, and angiotensin-converting enzyme inhibitors on pneumonia-related outcomes. *Clin Infect Dis*. 2012;55:1466–1473.
18. Wu A, Good C, Downs JR, Fine MJ, Pugh MJ, Anzueto A, Mortensen EM. The Association of cardioprotective medications with pneumonia-related outcomes. *PLoS One*. 2014;9:e85797.
19. Henry C, Zaizafoun M, Stock E, Ghamande S, Arroliga AC, White HD. Impact of angiotensin-converting enzyme inhibitors and statins on viral pneumonia. *Proc (Bayl Univ Med Cent)*. 2018;31:419–423.
20. Zhang P, Zhu L, Cai J, Lei F, Qin JJ, Xie J, Liu YM, Zhao YC, Huang X, Lin L, et al. Association of inpatient use of angiotensin converting enzyme inhibitors and angiotensin II receptor blockers with mortality among patients with hypertension hospitalized with COVID-19. *Circ Res*. 2020;126:1671–1681.
21. Bavishi C, Maddox TM, Messerli FH. Coronavirus disease 2019 (COVID-19) infection and renin angiotensin system blockers. *JAMA Cardiol*. 2020;5:745–747.
22. Kuster GM, Pfister O, Burkard T, Zhou Q, Twerenbold R, Haaf P, Widmer AF, Osswald S. SARS-CoV2: should inhibitors of the renin-angiotensin system be withdrawn in patients with COVID-19? *Eur Heart J*. 2020;41:1801–1803.
23. Schmidt M, Schmidt SAJ, Adelborg K, Sundbøll J, Laugesen K, Ehrenstein V, Sørensen HT. The Danish health care system and epidemiological research: from health care contacts to database records. *Clin Epidemiol*. 2019;11:563–591.
24. Schmidt M, Pedersen L, Sørensen HT. The Danish Civil Registration System as a tool in epidemiology. *Eur J Epidemiol*. 2014;29:541–549.
25. Schmidt M, Schmidt SA, Sandegaard JL, Ehrenstein V, Pedersen L, Sørensen HT. The Danish National Patient Registry: a review of content, data quality, and research potential. *Clin Epidemiol*. 2015;7:449–490.
26. Christiansen CF, Møller MH, Nielsen H, Christensen S. The Danish intensive care database. *Clin Epidemiol*. 2016;8:525–530.
27. Pottegård A, Schmidt SA, Wallach-Kildemoes H, Sørensen HT, Hallas J, Schmidt M. Data resource profile: the Danish national prescription registry. *Int J Epidemiol*. 2017;46:798–798f.
28. Zou Z, Yan Y, Shu Y, Gao R, Sun Y, Li X, Ju X, Liang Z, Liu Q, Zhao Y, et al. Angiotensin-converting enzyme 2 protects from lethal avian influenza A H5N1 infections. *Nat Commun*. 2014;5:3594.
29. Khan A, Benthin C, Zeno B, Albertson TE, Boyd J, Christie JD, Hall R, Poirier G, Ronco JJ, Tidswell M, et al. A pilot clinical trial of recombinant human angiotensin-converting enzyme 2 in acute respiratory distress syndrome. *Crit Care*. 2017;21:234.
30. Thomsen RW, Riis A, Nørgaard M, Jacobsen J, Christensen S, McDonald CJ, Sørensen HT. Rising incidence and persistently high mortality of hospitalized pneumonia: a 10-year population-based study in Denmark. *J Intern Med*. 2006;259:410–417.
31. Blichert-Hansen L, Nielsson MS, Nielsen RB, Christiansen CF, Nørgaard M. Validity of the coding for intensive care admission, mechanical ventilation, and acute dialysis in the Danish National Patient Registry: a short report. *Clin Epidemiol*. 2013;5:9–12.
32. Phua J, Weng L, Ling L, Egi M, Lim C-M, Divatia JV, Shrestha BR, Arabi YM, Ng J, Gomersall CD, et al. Intensive care management of coronavirus disease 2019 (COVID-19): challenges and recommendations. *Lancet Respir Med*. 2020;8:506–517.
33. Sundbøll J, Adelborg K, Munch T, Frøslev T, Sørensen HT, Bøtker HE, Schmidt M. Positive predictive value of cardiovascular diagnoses in the Danish National Patient Registry: a validation study. *BMJ Open*. 2016;6:e012832.

SUPPLEMENTAL MATERIAL

Table S1. Codes.

Variable	Source/format	Look-back	Inclusion codes	Exclusion codes
Study population (ICD-10 codes)				
Any influenza or pneumonia	DNPR/ICD-10		J09-J18, A481, B012, A709	
Influenza	DNPR/ICD-10		J09, J10	
Pneumonia with bacterial or unspecified pathogen	DNPR/ICD-10		J13, J14, J157, J159, J180, J181, J182, J189, A481	
Main exposures (ATC codes)				
ACE-Is	NPD/ATC	90d	C09A, C09B	
ARBs	NPD/ATC	90d	C09C, C09D	
Calcium channel blockers (CCB)	NPD/ATC	90d	C07FB, C08CA, C09BB, C09DB, C09DX01	
Outcomes				
ICU admission	DNPR/Procedure		NABE, NABB	
Mechanical ventilation	DNPR/Procedure		BGDA0	
Non-invasive ventilation	DNPR/Procedure		BGDA1	
Treatment with inotropes/vasopressors	DNPR/Procedure		BFHC92A, BFHC92B, BFHC92C, BFHC92D, BFHC92E, BFHC93A, BFHC93B, BFHC93C, BFHC95	
Dialysis-treated acute kidney injury ("acute dialysis")	DNPR/Procedure		BJFD0	
Death	CPR/status			
Covariates				
Age	CPR			
Sex	CPR			
Coexisting conditions				
Hospital-diagnosed hypertension	DNPR/ICD-10	10y	I10, I15	
Diagnosed stable angina pectoris	DNPR/ICD-10	10y	I20, I251, I259	I21, I22, I23, I200
Myocardial infarction	DNPR/ICD-10	10y	I21, I22, I23	
Heart failure	DNPR/ICD-10	10y	I50	
Stroke	DNPR/ICD-10	10y	I60, I61, I63, I64	
Atrial fibrillation/flutter	DNPR/ICD-10	10y	I48	
Heart valve disease	DNPR/ICD-10	10y	I05, I06, I07, I08, I09.8, I34-I37, I39, I51.1A, Q22, Q23	
Venous thromboembolism	DNPR/ICD-10	10y	I26, I801, I802, I803	

Variable	Source/format	Look-back	Inclusion codes	Exclusion codes
Diabetes	DNPR/ICD-10	10y	E10, E11, E12, E13, E14, O24, G63.2, H360, N083	O24.4
	NPD/ATC	10y	A10A, A10B	
Chronic pulmonary disease	DNPR/ICD-10	10y	J40, J41-J44, J45-J47, J60-J67, J68.4, J70.1, J70.3, J84.1, J92.0, J96.1, J98.2, J98.3	
Renal disease	DNPR/ICD-10	10y	I12, I13, N00-N05, N07, N11, N14, N18-N19, Q61, N08, E102, E112, E142	
End-stage renal disease (kidney transplant or dialysis)	DNPR/Procedure	10y	BJFD2	
	DNPR/Surgery	10y	KKAS	
	DNPR/ICD-10	10y	T861, Z940	
Liver disease	DNPR/ICD-10	10y	B18, B150, B160, B162, B190, I85, K70, K71, K72, K73, K74, K760, K76.6	
Dementia	DNPR/ICD-10	10y	DF00, DF01, DF02, DF03, DG30, DG310B, DG311, DG318, DG319	
	NPD/ATC	10y	N06D	
Cancer	DNPR/ICD-10	10y	C00-C96, D459, D46, D471, D473, D474, D475	C44
Metastatic cancer	DNPR/ICD-10	10y	C76-C80, CxxxM	
Peptic ulcer disease	DNPR/ICD-10	10y	K221, K25-K28	
Rheumatoid arthritis or connective tissue disease	DNPR/ICD-10	10y	M05-M06, M30-M36, M45	
Co-medication				
Number of antihypertensive drugs	NPD/ATC	90d	0-5 (see below: ACE-I/ARB, CCB, Thiazides/diuretics, BB, other antihypertensive drugs)	
Thiazides/diuretics	NPD/ATC	90d	C03AA01, C03AA03, C03AB01, C03AB03, C03AX01, C03EA, C07B, C09BA, C09DA, C09DX01, C09DX03, C09XA52, C09XA54	C07BA06 C09BA04
Beta-blockers (BB)	NPD/ATC	90d	C07	
Other antihypertensive drugs	NPD/ATC	90d	C02AC, C02CA, C03BA11, C09XA C02AB01	C09XA54
Statins	NPD/ATC	90d	C10AA, C10B	
Aspirin	NPD/ATC	90d	B01AC06, N02BA01, N02BA51	
Loop diuretics	NPD/ATC	90d	C03C	
Antibiotics	NPD/ATC	10d	J01	
Antivirals	NPD/ATC	10d	J05	

Variable	Source/format	Look-back	Inclusion codes	Exclusion codes
Immunosuppressants	NPD/ATC	90d	L04	
Glucocorticoids	NPD/ATC	90d	H02AB	
NSAID use	NPD/ATC	90d	M01A	
Opioid use	NPD/ATC	90d	N02A, N07BC02	
Vitamin K antagonists	NPD/ATC	90d	B01AA	
Proton pump inhibitors	NPD/ATC	90d	A02BC	
Antidepressants	NPD/ATC	90d	N06A	
Hypnotics/sedatives	NPD/ATC	90d	N05C	
Antipsychotics	NPD/ATC	90d	N05A	
Lifestyle and social factors				
Markers of smoking (diagnoses or medications for tobacco smoking or chronic obstructive pulmonary disease)	DNPR/ICD-10	10y	J41-J44, DF17, DZ716, DZ720	
	NPD/ATC	10y	R03, N07BA	
Obesity diagnoses or medications	DNPR/ICD-10	10y	E66	
	NPD/ATC	10y	A08	
Alcoholism-related diagnoses or medication for alcohol deterrent	DNPR/ICD-10	10y	DF10, DE244, DG312, DG621, DG721, DI426, DK292, DK70, DK852, DK860, DQ860, DZ502, DZ714, DZ721	F100
	NPD/ATC	10y	V03AA, N07BB	
Marital status (widow, divorced, married, umarried)	CPR			
Rural/urban place of residence	CPR			

ATC Anatomical Therapeutic Chemical Classification System; CPR Danish Civil Registration System; DNPR Danish National Patient Registry; ICD-10 International Classification of Diseases 10th edition; NPD National Prescription Database.

Table S2. Characteristics all influenza/pneumonia patients, overall and by main outcomes.

	<i>Death within 30 days</i>	<i>ICU admission</i>	<i>Overall study population</i>
Number of patients	76 762 (100.0)	42 827 (100.0)	568 019 (100.0)
Age, median (Q1–Q3)	81.7 (73.0–88.0)	70.4 (60.4–78.7)	73.4 (60.5–82.9)
Male	41 696 (54.3)	24 945 (58.2)	290 847 (51.2)
Coexisting conditions (within prior 10 years)			
Hospital-diagnosed hypertension	26 779 (34.9)	13 096 (30.6)	168 929 (29.7)
Previous myocardial infarction	6 650 (8.7)	3 225 (7.5)	39 765 (7.0)
Diagnosis of stable angina pectoris	10 512 (13.7)	4 932 (11.5)	68 458 (12.1)
Heart failure	13 714 (17.9)	5 745 (13.4)	71 110 (12.5)
Stroke	13 312 (17.3)	4 745 (11.1)	65 390 (11.5)
Atrial fibrillation/flutter	18 205 (23.7)	6 782 (15.8)	95 028 (16.7)
Heart valve disease	6 330 (8.2)	2 775 (6.5)	34 773 (6.1)
Venous thromboembolism	4 475 (5.8)	2 028 (4.7)	28 527 (5.0)
Diabetes	14 424 (18.8)	8 797 (20.5)	96 530 (17.0)
Chronic pulmonary disease	20 574 (26.8)	12 982 (30.3)	158 700 (27.9)
Renal disease	7 039 (9.2)	3 644 (8.5)	40 703 (7.2)
End-stage renal disease	974 (1.3)	778 (1.8)	8 866 (1.6)
Liver disease	2 489 (3.2)	2 398 (5.6)	15 306 (2.7)
Dementia	9 755 (12.7)	1 226 (2.9)	35 086 (6.2)
Cancer	21 387 (27.9)	7 110 (16.6)	106 704 (18.8)
Metastatic cancer	5 178 (6.7)	903 (2.1)	18 613 (3.3)
Peptic ulcer disease	6 101 (7.9)	3 209 (7.5)	32 653 (5.7)
Rheumatoid arthritis or connective tissue disease	4 173 (5.4)	2 260 (5.3)	32 740 (5.8)
Co-medication (prescription within 90 days)			
Total number of antihypertensive drugs			
0	39 555 (51.5)	22 989 (53.7)	322 012 (56.7)
1	21 680 (28.2)	9 923 (23.2)	130 685 (23.0)
2	11 318 (14.7)	6 659 (15.5)	81 190 (14.3)
3	3 523 (4.6)	2 582 (6.0)	27 956 (4.9)
4	648 (0.8)	631 (1.5)	5 832 (1.0)
5	38 (0.0)	43 (0.1)	344 (0.1)
ACE-I	11 915 (15.5)	7 239 (16.9)	82 358 (14.5)
ARB	6 342 (8.3)	4 189 (9.8)	53 255 (9.4)
CCB	10 093 (13.1)	6 553 (15.3)	71 116 (12.5)
Thiazides	11 343 (14.8)	6 265 (14.6)	79 879 (14.1)
Beta-blockers	17 332 (22.6)	9 050 (21.1)	111 315 (19.6)
Other antihypertensive drugs	882 (1.1)	633 (1.5)	6 238 (1.1)
Statins	13 882 (18.1)	9 271 (21.6)	112 995 (19.9)
Aspirin	20 813 (27.1)	9 308 (21.7)	120 295 (21.2)
Loop diuretics	26 763 (34.9)	10 768 (25.1)	127 995 (22.5)
Immunosuppressants	716 (0.9)	555 (1.3)	6 744 (1.2)
Glucocorticoids	13 864 (18.1)	5 765 (13.5)	78 980 (13.9)
NSAID	9 173 (11.9)	5 957 (13.9)	68 602 (12.1)
Opioids	28 517 (37.1)	10 859 (25.4)	144 942 (25.5)
Vitamin K antagonists	5 315 (6.9)	3 044 (7.1)	38 277 (6.7)
Proton pump inhibitors	25 845 (33.7)	10 954 (25.6)	147 542 (26.0)
Antidepressants	21 494 (28.0)	9 481 (22.1)	121 248 (21.3)
Hypnotics/sedatives	13 963 (18.2)	6 336 (14.8)	79 343 (14.0)

	<i>Death within 30 days</i>	<i>ICU admission</i>	<i>Overall study population</i>
Antipsychotics	7 673 (10.0)	3 725 (8.7)	39 434 (6.9)
Antibiotics (prescription within 10 days)	18 201 (23.7)	7 442 (17.4)	160 059 (28.2)
Antivirals (prescription within 10 days)	142 (0.2)	68 (0.2)	1 537 (0.3)
Lifestyle and social factors			
Markers of smoking	34 551 (45.0)	21 621 (50.5)	279 883 (49.3)
Obesity	3 622 (4.7)	3 908 (9.1)	44 194 (7.8)
Alcoholism	6 551 (8.5)	7 002 (16.3)	46 063 (8.1)
Marital status			
Widow	30 732 (40.0)	9 352 (21.8)	153 071 (26.9)
Divorced	10 552 (13.7)	7 780 (18.2)	85 766 (15.1)
Married	28 207 (36.7)	18 398 (43.0)	245 727 (43.3)
Unmarried	7 271 (9.5)	7 297 (17.0)	83 455 (14.7)
Urban residence	26 494 (34.5)	13 268 (31.0)	208 285 (36.7)

Figure S1. Study design.

